Date _____ MR#_____

Physical Therapy Medical Screening Questionnaire

Name: _____ **Gender:** ❑ **M** ❑ **F** **Age:** _____ **Height:** _____ **Weight:** _____

Hand Dominance: ❑ **R** ❑ **L** **Occupation:** _____ **Place of Employment:** _____

Past Medical History

Relevant past surgical or hospitalization history:

Please list all current medications:

Please list Allergies: _____

Have you recently experienced any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance (falls)
- ❑ muscle weakness
- ❑ numbness or tingling
- ❑ dizziness/lightheadedness
- ❑ changes in appetite
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ change in bowel or bladder function
- ❑ constipation/diarrhea
- ❑ increased pain at night
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you or a family member EVER been diagnosed with any of the following conditions (check all that apply)?

You ↓	Family ↓		You ↓	Family ↓		You ↓	Family ↓	
❑	❑	cancer	❑	❑	depression/anxiety	❑	❑	thyroid problems
❑	❑	heart problems	❑	❑	lung problems	❑	❑	diabetes
❑	❑	chest pain/angina	❑	❑	asthma	❑	❑	osteoporosis
❑	❑	high blood pressure	❑	❑	osteoarthritis	❑	❑	multiple sclerosis
❑	❑	circulation problems	❑	❑	rheumatoid arthritis	❑	❑	fibromyalgia
❑	❑	blood clots	❑	❑	other arthritic condition	❑	❑	eye problem/infection
❑	❑	stroke	❑	❑	bladder/urinary tract infection	❑	❑	epilepsy
❑	❑	anemia	❑	❑	kidney problem/infection	❑	❑	liver problems/hepatitis
❑	❑	bone or joint infection	❑	❑	sexually transmitted disease/HIV	❑	❑	ulcers
❑	❑	substance abuse	❑	❑	pelvic inflammatory disease	❑	❑	other _____

Have you had any falls in the last 6 months? ❑ **Y** ❑ **N** **If so, how many times have you fallen?** _____

Have you received any imaging? ❑ **X-ray,** ❑ **MRI,** ❑ **Other:** _____

Please describe your current issue and when it began. Date: _____

_____

_____

_____

_____

Date _____ MR#_____

Please circle the number which best represents the severity of your pain.

At WORST the last 72 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

At BEST the last 72 hours:

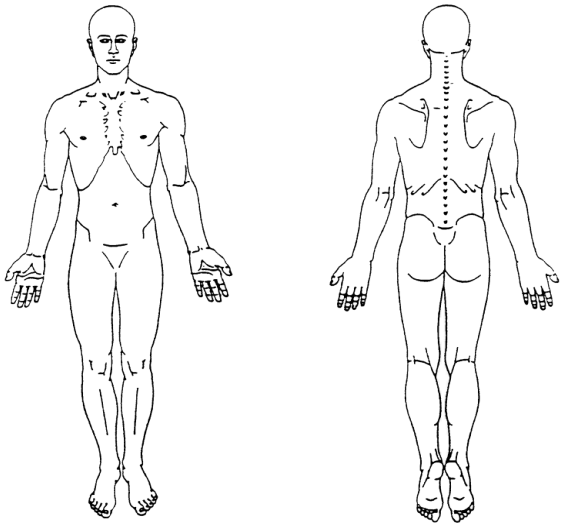
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

AVERAGE over the last 72 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Symptoms increase at night? ❑ Y ❑ N

Body Chart:
Please mark the areas where you feel pain on the chart to the right



What makes your symptoms worse?

What makes your symptoms better?

Have you received any treatment for this issue before? _____

Do you currently smoke? ❑ **Y** ❑ **N If so how many times per day?** _____

If you have quit smoking, how many years did you smoke for? _____

Do you consume alcohol? ❑ **Y** ❑ **N If so how many times per day?** _____

Do you use recreational drugs? ❑ **Y** ❑ **N**

Do you think you may be pregnant? ❑ **Y** ❑ **N**

Do you feel safe in your current living situation? ❑ **Y** ❑ **N**

Please list any functional activities you are currently having difficulty with or are unable to perform:

1. _____
2. _____
3. _____

What are your specific goals with physical therapy? _____

What methods of learning do you prefer? ❑ **Written Information** ❑ **Verbal Instruction** ❑ **Demonstration**

Patient Signature: _____

Parent or Guardian: _____